Report of the Sixth Meeting of Health Secretaries of the Countries of WHO South-East Asia Region

Yangon, Myanmar, 19-21 February 2001

WHO Project: ICP DGO 001

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The Report
Section 1

INTRODUCTION

The Regional Director, WHO South-East Asia Region (SEAR), convened the Sixth Meeting of Health Secretaries of SEAR countries in Yangon, Myanmar, from 19-21 February 2001. The objectives of the meeting were to review:

- progress on control of diseases and other health problems;
- programme budget 2002-2003: intercountry cooperation, including recommendations of:
  - the 18th Meeting of Health Ministers, and
  - the High-Level Task Force on Intercountry Collaboration;
- health care financing, and
- health systems performance.

The Agenda of the meeting is at Annex 1.

The meeting was hosted by the Ministry of Health, Government of the Union of Myanmar. It was attended by the Vice-Minister of Health, DPR Korea; Deputy Minister of Health, Myanmar; Health Secretaries of Bangladesh, Bhutan, India, Indonesia, Nepal, Sri Lanka and Thailand, and Head of the Project Planning and Monitoring Section, Maldives (see Annex 2 for the List of Participants).

The meeting was inaugurated by H.E. Maj. Gen. Ket Sein, Minister of Health, Government of the Union of Myanmar.
Section 2

INAUGURAL SESSION

H.E. MAJ. GEN. KET SEIN, Minister of Health, Government of the Union of Myanmar, in his inaugural address, affirmed that the Health Secretaries’ Meeting was very important as it served as a forum for exchanging views and experiences regarding health and health-related matters in the Member Countries. It also gave a practical shape to the policies emanating from the Health Ministers’ Meeting.

The Minister observed that over the years there had been considerable changes in the political, economic and social conditions all over the world. It was, therefore, only natural that the Member Countries had to meet those changing conditions and challenges. It was highly commendable that WHO was trying to improve and intensify its efforts to fulfil the health development needs of the Member Countries.

The Minister recalled that the 18th Health Ministers’ Meeting, held in Nepal, agreed that the intercountry programme (ICP) and the country programmes were complementary to each other in supporting national health development in Member Countries. ICP activities were designed to assist Member Countries with special emphasis on collaboration among the countries concerned. In pursuance of the recommendations of the Ministers, the Regional Director had formed a High-Level Task Force, which had already met twice.

H.E. Maj. Gen. Ket Sein said that health played a pivotal role in overall development. Promotion of Health and social development was vital for enhancing the quality of life. In accordance with his country’s social objective of uplifting the health standards of the entire people, the Government of Myanmar had accorded priority in the allocation of government budget to the health sector. This had greatly contributed to the improvement of the standards of health care in the country in recent years. At the same time, the Ministry of Health had carried out health sector reforms with the aim of increasing equity, efficiency and quality of health services. Broadly speaking,
the reform had encompassed policy, organization, institutional development, human resources, health financing and the private sector. The Minister also apprised the meeting of the efforts being made for the prevention and control of malaria, tuberculosis and HIV/AIDS.

In conclusion, H.E. Maj. Gen. Ket Sein expressed his deep appreciation of the valuable contribution made by the earlier meetings of Health Secretaries in fostering regional collaboration and promoting health development in the Region (for full text of the address, see Annex 3).

Dr Uton Muchtar Rafei, Regional Director, WHO, said that the Sixth Meeting of Health Secretaries - the first in the 21st century - was being held at a time of great opportunities and challenges. It would, therefore, be appropriate to critically review WHO’s achievements and remind itself of what needed to be done to achieve its goals. There had been significant health gains over the past 50 years. After eradicating smallpox, the South-East Asia Region recently achieved eradication of guineaworm disease. Together with the Member Countries, WHO would soon eradicate polio and eliminate leprosy. Neonatal tetanus as well as micro-nutrient deficiencies were also being tackled vigorously.

Dr Uton stated that problems of tuberculosis and malaria had been further aggravated by noncommunicable diseases that were fast becoming a public health concern in the Region. HIV/AIDS was threatening to offset the Region’s hard-won health and socioeconomic gains. The increase in tobacco consumption was also a cause for grave concern. Poverty was the root cause of most of the health challenges confronting the countries. Fortunately, the growing recognition of the centrality of health in development provided a solid base for hope and optimism. Links between health and development, and between poverty and ill-health were being widely appreciated. Development partners such as the World Bank and other donor agencies were increasingly supporting health initiatives as a key to development and poverty alleviation. He called upon the Member Countries to take full advantage of the new orientation of WHO’s development partners and donors.

Referring to the observation that often the lack of resources was a hindrance in improving the health and well-being of the people, particularly the poor, Dr Uton said that there was evidence to show that even in poor economies, major health improvements could be achieved by using the available resources in socially productive ways (for full text of the address, see Annex 4).
Section 3

INTRODUCTORY SESSION

DR UTON MUCHTAR RAFEI, Regional Director, WHO, apprised the participants of the important developments and events that had taken place since their last meeting in February 2000.

Dr Uton recalled that the Fifty-third World Health Assembly had deliberated upon the Stop TB Initiative and addressed the problem of HIV/AIDS. The Assembly had endorsed the Global Alliance for Vaccines and Immunization. It urged the Member States to integrate food safety as one of their essential public health and public nutrition functions. Dr Uton also recalled that the WHO Regional Committee for South-East Asia had considered the Proposed Programme Budget 2002-2003 and deliberated upon blood and food safety. The Committee urged the Member States to adopt the Vision 2020 strategy and endorsed the proposed regional strategy for reduction of maternal mortality.

Dr Uton recounted the subjects deliberated upon by the Health Ministers at their 18th meeting which agreed that the intercountry programme (ICP) and country programmes were supplementary to each other in supporting national health development. The meeting recommended that an action plan to work out the operational details of an enhanced ICP should be prepared jointly by the Regional Office and the Member Countries. The Regional Director noted that the 107th session of the WHO Executive Board had considered topical subjects such as nursing and midwifery; health systems performance; global health security: epidemic alert and response; and infant and young child nutrition.

The Regional Director informed the meeting that follow-up action was being taken on the recommendations of the meetings of the Health Ministers and Health Secretaries.
Prof Kyaw Myint (Myanmar) and Mr Padam Prasad Pokharel (Nepal) were nominated as Chairman and Vice-Chairman respectively of the meeting.

A drafting group, consisting of Dr S.P. Agarwal (India), Mrs Nasirah Bahaudin (Indonesia), Dr Kyi Soe (Myanmar), Dr S.P. Bhattarai (Nepal) and Dr Wanchai Sattayawuthipong (Thailand) was established.
Section 4

BUSINESS SESSIONS

4.1 Review of progress on Control of Diseases and other Health Problems

The ten Member Countries of the SEA Region of WHO have one quarter of the global population and above 35% of the world’s poor. The burden of communicable diseases is high. Noncommunicable diseases, accidents and injuries are increasing. Resource allocation for health continues to be poor.

Notwithstanding the above, a number of achievements have been made by the countries of the Region. Guineaworm disease has been eradicated and poliomyelitis is close to eradication. Very good progress has been made in the elimination of leprosy and control of iodine deficiency disorders. The tuberculosis control programme is being rapidly expanded. Considerable progress has been made in disease surveillance. However, the capacity to deal with disease outbreaks and disasters must be increased and risk factor surveillance (including behavioural surveillance) needs to be improved. The gains made by diarrhoeal disease control and ARI control programmes have been consolidated into an integrated management of childhood disease strategy. However, concern was expressed about the HIV/AIDS pandemic and the problem of persistence of malaria. Maternal mortality ratios continue to be high and the incidence of low-birth-weight babies has not declined. The control of noncommunicable diseases, health problems relating to tobacco use and mental health problems requires adoption of a risk comprehensive approach. Strategies are now available for elimination of lymphatic filariasis and prevention of blindness. Elimination of kala azar, which is very feasible, is a regional priority. Challenges to be addressed in the coming decades include, rapid population growth, increasing urbanization, migration, environmental degradation, including water and sanitation, globalization and weak health infrastructure.
Solutions to address the numerous problems affecting health development in the countries of the Region include the following:

**Advocacy**, in order to sustain political will, deployment of resources, building and sustaining partnerships, using enhanced intercountry cooperation mechanisms to complement country efforts and stewardship.

**Availability** of knowledge, drugs, vaccines and commodities [e.g., insecticide treated bednets (ITBN), condoms] for priority selected conditions.

**Accessibility** should include physical and social access which ensures people’s participation to demand the services. Social accessibility must take into account local cultural differences.

**Affordability**. Interventions which are cost-effective must be chosen. Some illustrative examples include DOTS for TB, ORT for diarrhoea, antibiotics for pneumonia, measles vaccination, ITBN for malaria, and latex condoms for family planning and prevention of STD, HIV/AIDS. Costs should be covered by the public health system, NGOs and the people in accordance with the national policy.

**Assessment** through surveillance, research and development is important. Evidence should be linked to programming and planning. It can be utilized for advocacy and for partnerships.

Success can be achieved by scaling up application of the best available knowledge and tools used to reach the largest number of people, especially the poor and the vulnerable, in order to reduce disease burden and promote socioeconomic development.

**Discussion**

The progress on disease control and health problems and solutions was discussed. Representatives from all Member States shared their experiences on progress, achievements, constraints, challenges and opportunities. The following important conclusion and recommendations emerged during the discussion:

**Conclusion**

- Sustained political will, enunciated in the form of national health policy, National Health Act etc., is necessary. These should reflect decentralization of health care and move progressively towards the adoption of a programme approach rather than a project approach.
Recommendations

(1) Countries’ Financial commitment must be enhanced and sustained for greater use of cost-effective interventions ensuring accountability. A greater focus is required on preventive and promotive services in districts, especially those which are underdeveloped and have larger proportion of poor population.

(2) People’s participation at national and subnational levels needs to be enhanced taking into account local cultural aspects.

(3) Intercountry cooperation is the foundation of regional solidarity. This should be further enhanced by countries and WHO and coordinated with the country programmes so as to be fully complementary. Cross-border collaboration needs to be intensified to control the spread of diseases.

(4) Partnerships with civil society, private sector and development partners have to be strengthened and sustained. Capacity building is recommended.

(5) Disease surveillance (including risk factor and behavioural surveillance) must be enhanced by countries for improved response to epidemics and emergencies.

(6) Health systems research related to disease control needs to be promoted and programmes and services should be evidence based.

(7) WHO should provide technical support to the countries in disease surveillance and health systems research for disease control.

4.2 Review of Programme Budget 2002-2003: Intercountry Cooperation, including recommendations of:

18th Meeting of Health Ministers, and
High Level Task Force on Intercountry Collaboration

In pursuance of the recommendation of the Health Ministers, the Regional Director established a High-Level Task Force (HLTF) on Intercountry Collaboration, consisting of senior health officials of all Member States. A brief presentation was made on the work of the Task Force, whose terms of reference are given below:

(1) To identify thematic programme areas of work for implementation through intercountry collaboration;
(2) To identify intercountry/regional mechanisms for effective and efficient implementation of intercountry collaboration, and

(3) To assist the Regional Office in the joint planning of the draft intercountry programme detailed work plans for Programme Budget 2002-2003, based on the identified thematic programme areas of work.

The first meeting of HLTF took place at the WHO Regional Office, New Delhi, India, on 1-2 December 2000. Based on the policy guidance of the meeting of Health Ministers, the meeting of Health Secretaries, the Regional Committee, and WHO corporate and WHO country cooperation strategies, the Task Force established a set of eight criteria for the selection of thematic programme areas to be addressed through intercountry collaboration. Using these criteria, HLTF identified 13 technical content areas for developing supplementary intercountry programmes to be implemented during the biennium 2002-2003.

Within the general framework for intercountry collaboration and WHO Guidelines for preparing detailed work plans, reviews and discussions between WHO staff and national counterparts led to the development of detailed work plans for the 13 technical content areas. WHO-SEARO had set up interdepartmental working groups for drafting the work plans through consultations with WHO country offices. The draft work plans were sent to the countries for review and comments.

After finalization, the draft detailed work plans were reviewed in the second meeting of the Task Force, held at Yangon on 16-17 February 2001. After a thorough review of the expected results and related information for each content area, the Task Force agreed that “arsenic poisoning control”, initially addressed under the content area “Cross-border disease control”, should be made a separate (14th) content area.

The Task Force also reviewed and finalized expected results, indicators, targets and baseline data for each technical content area. It was noted that the levels established in the targets and the baselines may need to be revised prior to implementation. The Task Force proposed that the Regional Office should ensure full involvement and continuing participation of national programme managers in the development of the work plans. The final draft work plans, with budgetary details, will be submitted to the third meeting of HLTF, scheduled for June 2001. The Task Force will review and finalize the draft
work plans and recommend the same to the Regional Director. The Regional Director will then submit the final work plans to the 54th session of the WHO Regional Committee for South-East Asia in September 2001 for its consideration.

The Task Force proposed that the percentage of the total allocation for each of the continuing 10 content areas be 8%, and 5% for each of the new 4 content areas 5%. It recommended that either the total budget for the supplementary intercountry programme (ICP-II) to support the 14 content areas for Programme Budget 2002-2003 should be at the same level of funding as for ICP-II in the 2000-2001 biennium or it should be at a reduced level reflecting the percentage reduction for RO/ICP in the biennium 2002-2003.

In order to appreciate the recommendations of HLTF in a wider perspective, a presentation on the WHO programme budget was made. Data on the size of WHO-SEARO’s Regular Budget from biennium 1994-1995 to biennium 2002-2003 were presented. The Regular Budget could be analysed under two headings: Intercountry Programme Regional Office (25% of total allocation) and Country Programmes (75%). It was emphasized that the expenditure on staff and activities in support of Member States falls into both these categories.

The progress to date in implementing the budget for the current biennium (2000-2001) was analysed. While implementation had improved, the target of 75% at the end of the first year of the biennium has not been achieved. Because of slow implementation, a large amount of funds not spent during the biennium is likely to be carried over to the first year of the next biennium. As per WHO’s financial regulations, carry-over of funds, not used by the end of the first year, are surrendered to WHO/HQ as casual income. In fact, about 3.5% of total budget allocation for 1998-1999 was thus surrendered. Such carry-over of funds adversely affects programme implementation.

Discussion

All countries recognized the importance of the Supplementary ICP mechanism. It was agreed that regional solidarity is a key characteristic of the SEA Region. Following detailed discussion, which ranged from allocation of funds in the Proposed Programme Budget 2002-2003 to the extent of funds surrendered to Casual Income in addition to the size and scope of the Supplementary Intercountry mechanism, the following conclusions and recommendations emerged:
Conclusions

- There is an absolute need to ensure that funds allocated to the SEA Region are spent quickly and effectively on priority programmes.
- The funding for supplementary ICP (ICPII) should be at least at the same level as for the 2000-2001 biennium (i.e. US$ 3.73m).
- The Regional Director should pool the funds, other than WHO operating expenses, which have not been obligated by 30 June 2003, and also take necessary action to use the pooled funds for implementing intercountry programme proposals supporting priority programmes and flagship projects.

The above modality was expected to ensure that the contribution to meet the shortfall of outlay for ICP-II will be shared by all countries on the one hand and the Regional Office on the other.

One country did not agree with the wording of the conclusion on the use of unobligated funds. It felt that the conclusion should explicitly state that the pooled money from unobligated funds should not finance expenditure on supplies and equipment and long-term staff.

Recommendations

1. The funding for supplementary ICP (ICP-II) should be at least at the same level as for the biennium 2000-2001 (i.e. US$ 3.73m).

2. The Regional Director should pool the funds, other than WHO operating expenses, which have not been obligated by 30 June 2003, and also take necessary action to use the pooled funds for implementing intercountry programme proposals supporting priority programmes and flagship projects.

4.3 Health Care Financing

In the presentation on health care financing, it was pointed out that an analysis of the available data revealed that the total health expenditure as a percentage of GDP had remained at the same level for the past few years with the Region tending to invest less in health as compared to other regions. The average total health expenditure as a percentage of GDP was around 2 to 8%.
The proportion of health expenditure by government ranged from 30 to 80% of the total health expenditure. Due to the economic crisis in some countries, a reduction of public investment in health was observed in recent years. In some countries, 10-30% of the public expenditure consisted of external assistance in the form of either loans or grants. With globalization, trade liberalization and increasing promotion of private health care, there was an increasing trend of investing in high-cost low volume technologies, e.g. CT scan, MRI, lithotripsy, etc. When actual household expenditure for health care was analysed, it was noted that in some countries low-income households proportionately spend more in relation to their disposable income. In some instances, this regressivity of health care expenditure had resulted in decreased utilization by low-income household leading to their further impoverishment. Some governments had initiated policy measures to protect against financial risks for health care, especially for the poor. Various health insurance schemes (mandatory and voluntary social health insurance) and subsidy programmes (health cards, free service for low-income, donations, trust funds) were introduced during the last two decades.

It was suggested that the health ministries should work closely with the legislative bodies and finance ministries in order to obtain higher allocation of public revenues, including the possibility of increasing health investment using funds from earmarked indirect taxes. Appropriate policy options might be adopted for greater investment in public health interventions that use low-cost high volume technologies. Internal resources are important assets in establishing national foundations, trust funds and associations.

With the exception of Thailand and Indonesia, there was a low level of health insurance coverage in the Region. An appropriate policy needed to be adopted to expand the coverage of existing health insurance schemes. Countries without health insurance schemes should consider their adoption.

Discussion

It was noted that most countries lacked extensive health insurance schemes. In this regard, initiatives had been taken by medical schools, local governments and NGOs. Some countries had established revolving drug funds, trust funds and other community financing schemes. It was felt that WHO should support the development of guidelines for private health insurance providers and pricing of imported as well as price of locally-produced essential drugs.
It was suggested that WHO’s encouragement of health insurance schemes must be seen within the national context, particularly related to the people’s ability to pay. It was further noted that there was no evidence that the private sector is more cost effective than the public sector. A large-scale study needed to be undertaken in the rural areas to assess the feasibility of health insurance schemes.

Recognizing the limited budget allocation to the health sector, countries indicated alternative ways of using less costly health interventions, such as greater use of traditional medicine, involvement of the community in the provision of health care and concerted efforts to adopt healthy lifestyles.

The Regional Director, in the light of the above discussion, particularly relating to strategic purchasing, committed WHO’s assistance to the development of bulk purchasing arrangements for vaccines, medicines and raw materials for drug manufacture.

**Recommendations**

WHO should assist the Member States:

1. in the development of a database to assist in determining reasonable pricing of imported essential drugs as well as those locally produced;

2. in undertaking a large-scale study to assess the feasibility of health insurance schemes, particularly in rural areas, including a determination of the public sector subsidies required to supplement the limited ability of payment by those below the poverty line, and

3. in the development of bulk purchasing arrangements for vaccines, medicines and raw materials for drug manufacture.

**4.4 Health Systems Performance**

A brief presentation on health systems performance was made. The framework of the health system performance was reviewed noting the distinctions between allocative and technical efficiency as well as equality and equity. Since equity is the most salient feature of Health for All, its measurement could give a better indication of where countries stand in terms of their achievement.
The reaction of the countries of the Region to the World Health Report 2000, particularly issues raised in terms of the conceptual framework employed; reliability and use of limited data for analysis; rankings of countries based on social outcomes; political dimension of the rankings; and the limited and inadequate consultation with countries were noted. The Director-General’s proposal at the 107th session of the Executive Board were noted along with the adoption by the EB of the following measures to address the concerns raised by the Member States:

(a) A scientific peer review to be undertaken to review the framework and methodologies used;

(b) Close involvement and consultation with Member States, including sharing of draft Performance Assessment Report, at least 15 days prior to its publication;

(c) Efforts to improve the quality of data used, and

(d) Impacts of health systems performance assessment on policy and practice of health development in Member States to be reported to them.

The Director-General has agreed to present the report as an annex to the World Health Report every other year, with the next report to be issued in October 2002.

Addressing follow-up actions in SEAR, in collaboration with WHO headquarters, it was noted that four countries – India, Indonesia, Myanmar and Thailand - would join in a pilot effort to build capacity for better assessing health systems performance through the “Enhancing health systems performance initiative (EHSPI).” Sri Lanka and Nepal expressed interest in participating in this initiative.

Other follow-up actions include:

- updating of national health accounts;
- updating data on burden of disease and healthy life expectancy;
- undertaking health systems responsiveness surveys through household surveys in four countries (India, Indonesia, Myanmar and Thailand), key information surveys in all countries and postal and facility surveys in selected countries, and
- strengthening national health information systems, research capability, and policy reviews.

It was noted that SEARO planned to convene a Regional Consultation on Health Systems Performance Assessment in the second quarter of 2001 to further discuss the follow-up actions to be taken in the Region.

Discussion

The importance of informing Member States of the methodology used in rankings was emphasized. The issue of validity of data was raised by one country, which noted that the data incorporated in the World Health Report 2000 did not accurately represent the health situation. Countries noted their support for the concept of health performance assessment and provided examples of national efforts undertaken to improve the quality and availability of data in support of such assessments.

The Regional Director emphasized the significant efforts made in SEAR and at the 107th session of the Executive Board to address the deficiencies in the report, and assured that SEARO would take necessary actions to facilitate collaboration with countries, other regions and WHO headquarters.
Section 5

ADOPTION OF THE REPORT

AFTER DUE DELIBERATIONS, the participants adopted this report along with the conclusions and recommendations as noted under Section 4.
The Report

Section 6

CLOSING SESSION

THE PARTICIPANTS THANKED the Ministry of Health of the Government of the Union of Myanmar for hosting the meeting. They expressed their appreciation for the excellent arrangements made for conducting the meeting and also for their stay. They also thanked the government for their hospitality. They felt that the field trip to U-Do was useful and interesting. They thanked Dr Uton Muchtar Rafei, Regional Director, WHO, for organizing the meeting in an efficient manner and providing the requisite technical support. They also complimented Prof Kyaw Myint and Shri Padam Prasad Pokharel, Chairman and Vice-Chairman respectively of the meeting, for conducting the meeting efficiently.

The Chairman affirmed that the deliberations during the meeting were very useful and that its outcome would reinforce the countries’ efforts in achieving the targets set out in the WHO collaborative programme for 2002-2003. He was confident that the meeting would further enhance collective self-reliance in health development in the countries of the Region and foster regional solidarity. He thanked the Regional Director for the efficient technical support provided for the meeting.

Dr Uton Muchtar Rafei, Regional Director, expressed his happiness at the success of the meeting, as it fully achieved its objectives. He felt that necessary action should now be initiated by all concerned on the recommendations of the meeting. He placed on record his appreciation for the contribution of the Chairman and the Vice-Chairman to the success of the meeting. He also thanked the Ministry of Health of Myanmar for the excellent arrangements made for the meeting.

The Chairman then declared the Sixth Meeting of Health Secretaries of the countries of the WHO South-East Asia Region closed.
Annexes
Annex 1

AGENDA

1. Inaugural Session
2. Introductory Session
3. Review of Progress on Control of Diseases and other Health Problems
4. Review of Programme Budget 2002-2003: Intercountry Cooperation, including recommendations of:
   - 18th meeting of Health Ministers, and
   - High Level Task Force on Intercountry Collaboration
5. Health Care Financing
6. Health Systems Performance
7. Field Visit
8. Adoption of Conclusions and Recommendations
9. Closing Session
Annex 2

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TEXT OF ADDRESS BY H.E. MAJOR GENERAL KET SEIN, MINISTER FOR HEALTH, GOVERNMENT OF THE UNION OF MYANMAR

I would first of all like to extend a most cordial welcome to all of you to the Sixth Meeting of Health Secretaries of the WHO South-East Asia Region. Allow me also to express my sincere appreciation to the Health Secretaries who are attending the meeting despite their heavy schedules and commitments in their respective countries. The Health Secretaries’ Meeting is very important because it has served as a forum for exchanging views and experiences regarding health and health-related matters in our countries. It has given a practical shape to the policies emanating from the Health Ministers’ Meeting.

Over the years, there has been considerable changes in the political, economic and social conditions all over the world. It is only natural that we have to act accordingly to meet these changing conditions and challenges. It is highly commendable that WHO is forever trying to improve and intensify its efforts to fulfil the health development needs of Member Countries.

At the 18th Health Minister’s Meeting in Nepal, it was concluded that the Intercountry Programme (ICP) and the Country Programmes were complementary to each other in supporting national health development. ICP activities are designed to assist Member Countries with special emphasis on collaboration among the countries concerned. Following upon the recommendations, the Regional Director has formed a high-level task force. At its first meeting in New Delhi, it has identified the thematic programme areas of work for implementing through intercountry collaboration. The second meeting of the high-level task force here, in Yangon, has drawn up a plan of action and joint evaluation mechanisms that will be presented to the honourable Health Secretaries.

Health plays a pivotal role in development. Promotion of health and social development is vital for enhancing the quality of life. In accordance with the country’s social objective of uplifting the health standards of the
entire people, the Government of the Union of Myanmar has accorded priority in the allocation of the government budget to the health sector and the Ministry of Health is one of the largest recipients of budgetary funds. This has greatly contributed towards the improvement of health care standards in the nation in recent years.

Meanwhile, the Ministry of Health has carried out health sector reforms with the aim of increasing equity, efficiency and quality of health services. Broadly speaking, the reform has encompassed policy, organization, institutional development, human resources, health financing and the private sector.

Allow me to highlight a few areas on which the Government of Myanmar is accordng emphasis. Enhancing the quantity and quality of health professionals and ensuring an equitable distribution of human resources for health is a priority. Strengthening and upgrading of institutional capacity for the production of health professionals is under way. Plans are under way to open a new Institute of Medicine later this year in Magway, which is in central part of Myanmar. The Institute of Community Health in Magway, the Institute of Nursing, the Institute of Paramedical Sciences and the Institute of Pharmacy in Mandalay have all been strengthened to ensure an optimal mix of health manpower throughout the country. On the other hand, service-providing health institutions have also been upgraded - both in terms of infrastructure, staffing, medical equipment and drugs, ensuring the community with access to quality health care.

The Government has ensured the development of all sectors in harmony with the natural strength, human resources, growing population, changing environmental conditions, global situation and advances in science and technology.

Due to the endeavours of the Government, the issue of armed insurgency that had plagued the nation for over four decades has virtually ended and peace and stability prevail throughout the nation. This has created an environment that has enabled the Government to embark on development programmes, ensuring quality health care services all over the country, including the under-served regions, particularly in the border areas.

To promote health and well-being of the people, Myanmar has adopted strategies that are very similar to the four strategic directions that are outlined
in the WHO corporate strategy. The main strategies identified by the Ministry of Health are:

(1) widespread dissemination of health information and education to reach the rural areas down to the grassroot level;

(2) enhancing disease prevention activities, and

(3) providing effective treatment for prevailing diseases.

In addition, developing human resources for health, strengthening health facilities for enhancing quality of care; fostering and strengthening partnership in health development; strengthening alternative health care; health care financing; strengthening research and development and promoting traditional medicine are also important strategies.

In Myanmar, we have kept up with the changing international health situations and have instituted necessary measures to meet the challenges and fulfil the needs of our people. Under the guidance of the National Health Committee, chaired by H.E. Lt. General Khin Nyunt, Secretary (1) of the State Peace and Development Council, a coordinated, focused and holistic approach have been applied to health and health sector development. A life course perspective in planning health care services has been adopted. Special emphasis has been accorded to nutrition, health education, promoting life skills and adoption of behaviours conducive to health. Ensuring safe and healthy environments - especially provision of safe water, sanitation and improving maternal and child care have been promoted.

A concerted effort is also being made, both at the national level as well as the regional level, for the prevention and control of malaria and tuberculosis, which are major health problems in our region. Activities spelled out under the Roll Back Malaria and STOP TB initiatives are well under way. Through national-level committees, political support has been mobilized and multisectoral involvement in prevention and control activities have been enhanced.

On the issue of HIV/AIDS, the National Health Committee recently held a meeting to review ongoing prevention and control activities. As a result, a more active multisectoral coordinated effort, including local and international NGOs, have been adopted. The current 100% blood safety programme will be maintained and a second-generation sentinel surveillance programme has
been established with the sentinel sites expanded to cover 27 townships of all the States and Divisions. Behavioural sentinel surveillance is being strengthened and the School Based Healthy Living and AIDS Prevention Education programme will be expanded to cover school children of 4th to 9th grades. A 100% condom use among migrant workers, seafarers and other high-risk groups has been launched. More widespread dissemination of information and health education in a culturally appropriate manner will be maintained. The traditional cultural values of Myanmar uphold certain norms of behaviour, particularly regarding sexuality. These behaviours will be reinforced and promoted. Cross-border collaboration activities will also be implemented for preventing the transmission of HIV/AIDS.

I deeply appreciate your valuable contributions in fostering regional collaboration and promoting health development in the Region. The Health Secretaries Meeting has been extremely useful. Not only have they been able to address regional health problems but have also been able to formulate sound plans of action and strategies to tackle issues of common concern. I am confident that with your collective efforts, intercountry cooperation can be further strengthened to effectively reduce the burden of ill-health in the countries of the Region.

In conclusion, I would like to thank you again for attending this meeting. I am sure your deliberations would be most productive and that your stay in Myanmar will be pleasant and enjoyable.

Thank you.
Annex 4

TEXT OF ADDRESS OF DR UTON MUCHTAR RAŒI,
REGIONAL DIRECTOR, WORLD HEALTH ORGANIZATION

It gives me great pleasure to welcome you to this Sixth Meeting of Health Secretaries, which is being so graciously hosted by the Ministry of Health, Government of the Union of Myanmar. We are deeply honoured that His Excellency Major General Ket Sein is present here with us.

I also extend my greetings and a warm welcome to the distinguished participants. This is an important meeting – the first in the 21st century – being held at a time of great opportunities and great challenges. It would, therefore, be appropriate to critically review our achievements and remind ourselves of what needs to be done to achieve our goals.

Humanity has gained significantly from the unprecedented health gains over the last 50 years. Life expectancy has increased from less than 47 years in 1950-55 to over 64 years in 2000. This increase has been more pronounced in the developing countries; our Region too has gained much from this revolution. After eradicating smallpox, our Region recently achieved eradication of guineaworm disease. Together, we will soon eradicate polio and eliminate leprosy. Neonatal tetanus as well as micro-nutrient deficiencies are also being tackled vigorously.

Unfortunately, problems of tuberculosis and malaria have been further aggravated with noncommunicable diseases fast becoming a public health concern in the Region. HIV/AIDS is threatening to offset our hard-won health and socioeconomic gains. The increase in tobacco consumption is also a cause for grave concern. We must contain HIV/AIDS and the tobacco epidemic before it is too late. High infant mortality rates and maternal mortality ratios also warrant urgent attention.

We have to address the unfinished agenda in the face of widespread poverty, illiteracy and gender bias against women. In the current and coming decades, population growth, rapid and unplanned urbanization and
industrialization, as well as environmental risks and threats to health will continue to pose serious challenges to health development.

Poverty is the root cause of most of these challenges. Fortunately, the growing recognition of the centrality of health in development provides a solid base for hope and optimism. Today, as never before, there is wide appreciation of the links between health and development, and between poverty and ill-health. Development partners like the World Bank and donor agencies are increasingly supporting health initiatives as a key to development and poverty alleviation.

We must, therefore, take full advantage of the new orientation of our development partners and donor countries. The Regional Conferences of Parliamentarians, held in Kathmandu in November 1999 and in Dhaka in November 2000, underlined the urgent need for partnership amongst all to combat diseases of poverty and to improve the health of the poor and thus contribute to poverty alleviation. WHO, as a specialized technical agency, has launched a massive effort against the said diseases of poverty. The Director-General of WHO has established a Commission on Macroeconomics and Health to clarify the economic links between health and poverty reduction. She has also constituted a Task Force on Health and Poverty Reduction.

Often, the lack of resources is cited as a hindrance in improving the health and well-being of the people, particularly the poor. But, there is evidence to show that even in poor economies, major health improvements can be achieved by using the available resources in socially productive ways. This has been confirmed by no less a person than Prof Amartya Sen, the Nobel laureate. The remarkable progress that our countries are making in polio eradication also demonstrates that health development requires strong leadership, political will and social mobilization.

At this juncture, I am pleased to recall that at the Health Ministers, at their thirteenth meeting in Colombo in 1995, had recommended holding of regular meetings of the Health Secretaries with a view to providing a direct interface between the governing bodies of WHO and the highest functionaries in the national health ministries. It was felt that a forum of Health Secretaries would promote regional cooperation and solidarity.

The contributions of the Health Secretaries to the health of the people and to regional solidarity have been well established. During their second
meeting in February 1997 in Bali, the Health Secretaries discussed various aspects of health development in the Region in the 21st century. This contributed to the adoption of the Declaration on Health Development in the South-East Asia Region in the 21st Century by the Health Ministers at their meeting in August 1997. Further, at their meeting in Bali, the Health Secretaries agreed to pool a part of the country budget which could not be absorbed in time, for implementation through an intercountry mechanism. These important and timely decisions ensured full utilization of the regional budget for the 1996-1997 biennium. Very importantly, it was this strategy, carved out by the Health Secretaries during their third meeting in Bangkok that protected the allocation of WHO’s Regular Budget to our Region.

I have no doubt that the current meeting would further enhance regional solidarity and promote the interests of the countries of our Region. During this meeting, the Health Secretaries will deliberate and propose practical mechanisms to further strengthen intercountry cooperation in the context of programme budget 2002-2003. The Health Secretaries will also discuss Health Care Financing and Health Systems Performance and make recommendations so that equity and social justice are harmonized keeping in view efficiency in implementation. Further, the Health Secretaries will review the progress on control of diseases and other common health problems and recommend feasible strategies to carry forward our collective fight against them. We look forward to the guidance of the Health Secretaries in these important areas. I am confident that, as in Bali in 1997, the Health Secretaries would recommend practical ways to ensure full utilization of WHO’s Regular Budget by the SEA Region and its Member States.

Before concluding, may I, on behalf of all of us, thank His Excellency Major General Ket Sein, Hon’ble Health Minister, for so graciously agreeing to inaugurate this meeting. His address, I am sure, will set the tone for this meeting. It would also provide guidance to our efforts in combating diseases and improving the health of the people of our Region.

I would, once again, like to thank the Health Secretaries for attending this meeting. I am confident that their deliberations would be productive and that their stay in Yangon will be pleasant and comfortable.

Thank you.